Benesight

FIRST NOTICE OF CLAIM

Send to:
Az Foundation for Medical Care
P.O. Box 2909
Phoenix, AZ 85062-2902

PART 1: Employee Information

Employee Name (*Last and First*)	Employee Date of Birth / /	Employee Social Security Number - -	Employee Telephone Number ( )

Employee Address *Number* *Street* *City* *State* *Zip*

PART 2: Patient Information

Patient's Name	Patient's Date of Birth / /	Patient's Social Security Number - -

IS PATIENT ☐ EMPLOYEE ☐ CHILD ☐ SPOUSE ☐ OTHER *Specify* _____

If claim is for dependent child age 19 or over indicate
☐ STUDENT *Give name and* ☐ part time
☐ HANDICAPPED *location of school* _____ ☐ full time

PART 3: Description of Claim

Nature of Illness or Injury	Occupational Illness or Injury? ☐ YES ☐ NO	If claim is due to an accident state when, where and how accident occurred.

Have you been treated for this Illness or Injury in the last 12 months? ☐ YES ☐ NO	If yes, state the name and address of the attending physician.

PART 4: Other Group Health Insurance

Is patient eligible for Medicare Benefits? ☐ YES ☐ NO If yes, enter the date of eligibility _____

Are other family Members employed? *If yes, indicate*
☐ YES ☐ NO

Social Security Number _____

Name and address of employer _____

Name, relationship _____

Is patient covered under another group health insurance plan?
☐ YES ☐ NO
If yes, indicate through plan of _____
☐ SELF ☐ DEPENDENT
☐ SPOUSE ☐ OTHER *Specify* _____

Name and address of other benefit carrier _____

Policy number _____

PART 5: Complete for all claims

I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse The TPA, Inc. to the extent of any overpayment which is in excess of the amounts payable under the benefit plan administered by The TPA, Inc.

Any person who knowingly and with the intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act

Employee Signature _____ **Date** - _____

PART 6: Claim Authorization

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for the services submitted but not to exceed the reasonable and customary charge for those services.	**Signed (Employee)** **Date**
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my examination or treatment.	**Signed (Patient or Parent if Minor)**

WHEN TO FILE A CLAIM

1. A new claim is being submitted for a different family member.
2. A new claim is being submitted for a completely different illness or injury.
3. Any health claim form is acceptable.

HOW TO FILE A CLAIM

1. Complete the applicable items on the reverse side.
2. Promptly mail this form with any itemized bills to **Arizona Foundation** for repricing.
3. If you receive additional bills in connection with this claim after you have mailed this form DO NOT COMPLETE ANOTHER FORM. Identify bills by adding the following:

   Employer's Name
   Employee Name and Social Security Number
   Patient Name

MAIL THE BILLS TO:

Arizona Foundation for Medical Care
P.O. Box 2909
Phoenix, AZ 85062-2902

All bills for items listed below must show:

DOCTORS - Type of Treatment and Diagnosis
REGISTERED NURSES - Hours worked
ANESTHESIA - Anesthesia time
X-RAY & LABORATORY TIME - Type of services rendered

WE ENCOURAGE ELECTRONIC CLAIM SUBMISSION